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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

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F 000	INITIAL COMMENTS During Annual Recertification Survey and Complaint Investigation Numbers TN26968, TN 28168, TN28270, and TN27823, completed on September 28, 2011, deficiencies were cited related to the survey findings and related to Complaint #TN 28270, under 42 CFR Part 482.13 Requirements for Long Term Care. Complaint numbers TN26968, TN28168, and TN27813 were not substantiated.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280	1. On 10-3-11 Resident # 24 received a written care plan invitation and was verbally invited by her Social Worker to attend her care plan meeting scheduled for 10/18/11. Resident #24 will be reminded of her care plan meeting on the morning of 10/18/11 and invited to attend by her Social Worker. Completed 10/18/11 2. Each and every Resident will receive a written care plan invitation prior to there care plan meeting and will be verbally reminded of there care plan meeting on the morning of their care plan meeting by their Social Worker. Completed 10/4/11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Bowers — TITLE: Administrator — (X6) DATE: 10/13/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	Continued From page 1 Based on record review, interview, and policy review, the facility failed to enable one resident (#24) of twenty-four residents reviewed to participate in planning care and treatment. The findings included: Medical Record review of Resident #24's Minimum Data Set revealed the resident was not cognitively impaired and scored a 15 on the Brief Interview of Mental Status (BIMS) which indicated a high level of cognitive and mental functioning. Interview with Resident #24 on September 28, 2011, at 8:55 a.m., in the resident's room, revealed Resident #24 had not been invited to care plan meetings. Further interview with the resident confirmed the resident had not been notified of any care plan meetings but would have liked to have attended these meetings if...had been invited. The resident also stated...felt...should have been involved in the care plan meetings. Review of the Care Plan Conference Summary records revealed no documentation of Resident #24 attending the care plan meetings on October 5, 2010, or July 19, 2011. Review of the facility's "Comprehensive Care Plan" policy revealed, "Social Services Staff and/or designee notifies resident and responsible party prior to each care plan meeting..." Interview with the Social Worker on September 28, 2011 at 10:00 a.m., in the social worker's office, revealed Resident #24 was scheduled for a care plan meeting on July 19, 2011, but there	F 280	3. Social Workers will keep copies of all written care plan meeting invitations and will document Resident and Responsible Party responses to the invitations in the Resident Medical Record on the date of the scheduled care plan meeting. Note; Short term Skilled Residents and their Responsible Parties will receive verbal invitations to schedule their care plan meetings from their Social Worker. Completed 10/12/11 4. Social Workers will review monthly in Continuous Quality Improvement meeting, the number of care plan meeting scheduled for the month, the numbers of those are plan meetings attended by Residents and /or their Responsible Parties and the number of care plan meeting invitation letters sent to ensure that this deficient practice does not recur. Completed 11/7/11 11/7/11	

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F 280	Continued From page 2 was no documentation of the meeting having occurred. Further interview with the social worker confirmed there was no documentation of Resident #24 being notified of the meeting or of the resident attending the meeting.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow the Care Plan developed for two residents (#5 and #17) of twenty-four residents reviewed. The findings included: Resident #5 was admitted to the facility on July 13, 2011, with diagnoses including Weakness, Confusion, Dementia, Hypertension, Joint Stiffness, Pressure Ulcers, and Urinary Tract Infection. Medical record review of the Minimum Data Set (MDS) dated September 7, 2011, revealed the resident was 8 out of 15 (moderately impaired for decision making) on the BIMS (brief interview for mental status), and required extensive assistance	F 282	1. Resident # 5 heel protectors were applies per care plan. Completed 9-27-11 Resident # 17 heel protectors were applies per care plan. Completed 9-27-11 Certified Nurse Technician # 4 and Certified Nurse Technician #6 received counseling reports regarding failure to follow care plan. Certified Nurse Technician # 6 completed 9-28-11 and certified Nurse Technician # 4 was on 19/28/11. 2. Residents that were care planned for heel protectors were audited by treatment nurse on 9/28/11 3. In service staff on check are cards during walking rounds, this includes auditing for heel protector use. Completed 10-6-11 In service in daily (Monday-Friday) compliance rounds, check for heel protectors. These rounds are conducted by management team. The team consists of Unit Managers (3), Risk Manager,	

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F 282	Continued From page 3 for bed mobility and one person physical assist for transfers. Medical record review of the Care Plan dated June 20, 2011, revealed "...right medial heel stage three...heel protectors on while in bed..." Observation on September 27, 2011, at 10:10 a.m., in the resident's room, revealed the resident lying on the bed without the heel protectors in place. Interview on September 27, 2011, at 8:45 a.m., in the resident's room, with Certified Nurse Technician #4 confirmed the resident was to have the heel protectors on while in the bed and the heel protectors were not in place. Interview on September 28, 2011, at 8:35 a.m., at the South Nurses' Station, with Licensed Practical Nurse (LPN) #2 confirmed the resident was to have the heel protectors on while in the bed and the care plan had not been followed. Resident # 17 was readmitted to the facility on September 23, 2011, with diagnoses including Urinary Tract Infection, Failure to Thrive, Dysphagia, and Pressure Ulcers Right Heel and Coccyx. Medical record review of the (MDS) dated September 13, 2011, revealed the resident had moderately impaired cognitive skills, extensive assistance with Activities of Daily Living (ADL) and set up help only for eating. Medical record review of the Care Plan dated July 13, 2011, revealed "...heel protectors on while in	F 282	4. Social Services (2), Housekeeping Supervisor, Staff Development Coordinator, Medical Records Clerk, and Restorative Nurse. Completed 10-17-11 Following Interdisciplinary Team meeting, designated attendees will visually observe residents discussed in meeting to verify that card and pare plan interventions are in place. Completed on 10-24-11. Inservice interdisciplinary team on the new process on 10-18-11. The Administrator will be responsible for the in service training of the team. The MDS Coordinator will be responsible for tracking the interdisciplinary team's observations of residents regarding care cards/care plans.	10/20/11

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F 282	Continued From page 4 bed..." Observation on September 27, 2011, at 7:35 a.m., and 8:25 a.m., in the resident's room, revealed the resident lying on the bed without the heel protectors in place. Interview on September 27, 2011, at 8:45 a.m., in the resident's room, with Certified Nurse Technician #6 confirmed the resident was to have the heel protectors on while in the bed and the heel protectors were not in place. Interview on September 28, 2011, at 8:35 a.m., at the South Nurses' Station, with Licensed Practical Nurse (LPN) #2 confirmed the resident was to have the heel protectors on while in the bed and the care plan had not been followed.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy and interview, the facility failed to follow the facility's policy for incontinence	F 315	1. Resident #5 was assessed by treatment nurse and preformed peri care to assure resident received per care per policy and procedure. Completed 9-27-11 Certified Nurse Technician # 5 was counseled with an in service regarding incontinent resident care Completed 9-29-11 On Resident # 17 the certified Nurse Technician was counseled with disciplinary action regarding lack of proper peri care and violation of infection control policies. Completed 9-28-11	

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F 315	Continued From page 5 care for two residents (#5 and #17) of twenty-four residents reviewed. The findings included: Resident # 5 was admitted to the facility on July 13, 2011, with diagnoses including Weakness, Confusion, Dementia, Hypertension, Joint Stiffness, Osteoarthritis, and Urinary Tract Infection. Medical record review of the Minimum Data Set (MDS) dated September 7, 2011, revealed the resident was a 8 out of 15 (moderately impaired for decision making) on the BIMS (brief interview for mental status), and required extensive assistance for personal hygiene. Observation on September 27, 2011, at 10:10 a.m., in the resident's room, revealed Certified Nurse Technician (CNT) #5 providing incontinence care for the resident who was incontinent of stool. Continued observation revealed the CNT cleansed the resident's perineal area using a wash cloth with soap and water to remove the stool; wiped from front to back then folded the wash cloth and went from front to back again, with visible stool on the cloth and did not rinse the perineal area. Review of the facility policy Incontinent Resident Care dated December 1, 2003, revealed "...always work from front to back...Wash, rinse and dry..." Interview with CNT #5 on September 27, 2011, at 10:10 a.m., in the resident's room confirmed the CNT had folded the wash cloth and reused a	F 315	2. and 3. In service training of nursing staff regarding incontinent resident care was completed on 10-6-11. Upon hire of each nursing staff must demonstrate during orientation proper incontinent care. Begin protocol on 10-21-11. Competency checklists will be implemented for Certified Nurse Technicians. Completed 10-19-11. Facility Certified Nurse Technicians will be checked-off on competencies by Nursing Administration team by 11-10-11 Competencies check off will be required there after on a annual basis. The Director of Nurses will be responsible for monitoring this program for compliance. 4 Monthly report will be submitted to the Quality Assurance Committee of all competencies offered and successfully completed each month. This report will be the responsibly of the Director of Nurses. Compliance will be achieved by 11-10-11	11/10/11

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F 315	Continued From page 6 soiled cloth with visible stool present, and did not rinse the peri area. Interview with Licensed Practical Nurse #2 on September 27, 2011, at 3:30 p.m., at the north Hall Nurses' Station, confirmed reusing the wash cloth with stool present, and not rinsing the peri area was not according to the facility's policy for incontinence care. Resident # 17 was admitted to the facility on September 23, 2011, with diagnoses including Urinary Tract Infection, Failure to Thrive, Dysphagia, and Pressure Ulcers Right Heel and Coccyx. Medical record review of the Care Plan dated June 20, 2011, revealed "...catheter care daily..." Observation on September 28, 2011, at 8:25 a.m., in the resident's room, revealed the CNT (#6) was providing incontinence care for the resident who was incontinent of stool. Continued observation revealed the CNT cleansed the resident's perineal area using a wash cloth with soap and water to remove the stool; wiped from front to back, then folded the wash cloth and wiped from front to back five times, with visible stool on the cloth; turned the resident to the right side and did not perform catheter care. Interview with CNT #6 on September 28, 2011, at 8:35 a.m., in the resident's bathroom, confirmed the CNT had reused the wash cloth contimated with visble stool to wipe the resident multiple times, did not rinse the perineal area and confirmed catheter care was not performed. Interview with Licensed Practical Nurse (LPN) #4	F 315		

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F 315	Continued From page 7 on September 28, 2011, at 8:35 a.m. at the South's Nurses' Station, confirmed reusing the wash cloth contaminated with the stool/not rinsing the perineal area did not follow facility policy and the catheter was to be cleaned during incontinence care.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility investigation notes, observation and interview, the facility failed to ensure a safety device was in place for one resident (#1), and failed to perform a safe transfer for one resident (#5) of twenty-four residents reviewed. The findings included: Resident #1 was admitted to the facility on May 16, 2011, with diagnoses including Diabetes Mellitus Uncontrolled, Long Term Insulin Use, Dysphagia, Tube Feeding, Muscle Weakness, History of Falls, and Difficulty Walking. Medical record review of the Minimum Data Set dated June 22, 2011, revealed the resident had moderate cognitive impairment and required	F 323	1. Resident #1 was assessed by charge nurse on both occasions: July 25th and July 27th,assisted back to bed, no injury noted with either incident. Alarm was turned on and checked for proper functioning. 2 CNT's associated with the July 25th and July 27th incidents were counseled relating to safety alarm being checked during walking rounds, Completed CNT 7-31-11, CNT 8-18-11. Resident # 5 the nurse did assess the resident for any injuries, none were found. 9-27-11. LPN # 2 and CNT # 7 were counseled regarding manual lifting vs. use of mechanical lift. By the Director of Nurses. 2. In-service nursing staff regarding checking alarms during walking rounds on July 26th and July 27th and October 6th 2011.	

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F 323	Continued From page 8 extensive assistance for bed mobility, transfers, and activities of daily living. Medical record review of a fall risk assessment dated June 16, 2011, revealed the resident was at risk for falls. Medical record review revealed the resident had a history of falls. Medical record review of a nurse's note dated July 25, 2011, revealed "...In bed at start of shift. Was found slid to mat and was rolling on floor, no injuries noted. Assisted with lift back into bed...Bed alarm wasn't on at the time...bed in low position mattress at bedside..." Review of the facility investigation conducted by the Risk Manager revealed "...Bed alarm was in place but was no turned on...Disciplinary action provided to CNA (certified Nursing Assistant)..." Continued review of facility investigations revealed the resident had a fall on July 31, 2011, "...Resident observed on floor and mat by nurse. Upon further investigation, resident attempted to transfer self from bed without assistance. Bed alarm was in place but was not turned on...No injury noted..." Observation of the resident on September 27, 2011, at 9:30 a.m. revealed the resident awake, dressed, wearing non-skid footwear, up in a wheelchair in the hallway in front of the nurse's station, with a personal alarm attached and turned on. Interview with the Risk Manager on September	F 323	3. In services nursing staff regarding the mechanical lift policy and procedure on 10-6, 2011 by the Restorative Nurse. Competency testing will be checked off on CNT;s by nursing Administration team by 11-10-11. The team consists of Director of Nurses, Risk Manager, Restorative Nurse, Treatment Nurse (2), Unit Manager (2), Medical Records, and Staff Development Coordinator. Competencies will include resident safety regarding alarms, transfers and mechanical lifts. The Director of Nursing will monitor this through the documented competency forms. 4. Monthly report will be submitted to the Quality Assurance Committee of all competencies offered and successfully completed each month this report will be the responsible of the Director of Nurses. Compliance will be achieved by 11-10-11	11/10/11

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F 323	Continued From page 9 28, 2011, at 9:30 a.m., in the Central Supply office, confirmed the bed safety alarm was not turned on when the resident fell on July 25 and 31, 2011. C/O #28270 Resident #5 was admitted to the facility on July 13, 2011, with diagnoses including Weakness, Confusion, Dementia, Hypertension, Joint Stiffness, and Urinary Tract Infection. Medical record review of the Minimum Data Set (MDS) dated September 7, 2011, revealed the resident was 8 out of 15 (moderately impaired for decision making) on the BIMS (brief interview for mental status), required extensive assistance for bed mobility and one person physical assist for transfers. Observation on September 27, 2011, at 3:30 p.m., revealed Licensed Practical Nurse (LPN) #2 and Certified Nurse Technician (CNT) #7 preparing to transfer the resident from the wheel chair to the bed. Continued observation revealed the LPN and the CNT transferred the resident, to the bed, with the LPN lifting the resident under the left arm and the CNT lifting the resident under the right elbow. Interview on September 27, 2011, at 3:48 p.m., with the facility's Registered Physical Therapist, in the therapy room, confirmed it was the policy and procedure of the facility not to manually lift the residents.	F 323		

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F 323	Continued From page 10 Interview on September 27, 2011, at 4:45 p.m., with the Director of Nursing (DON), in the DON office, confirmed mechanical lifts were to be used and it was inappropriate to lift a resident under the arms due to the potential for injury.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain proper sanitation for food preparation equipment, dishware, floors, safe food temperatures, and safe storage of refrigerated and dry foods in the dietary department. The findings included: Observation and interview on September 26, 2011, at 7:05 p.m., in the dietary department, with the head cook, revealed the outside of the ice maker was visibly covered with debris and confirmed the outside of the ice maker needed to be cleaned. Further observation revealed three dry storage bins labeled flour, meal, and sugar had debris and crumbs on the container lids.	F 371	1 & 2. Ice maker in dietary was cleaned on 9/26/11. Flour, sugar and meal bins were cleaned on 9/26/11. Mixer and toaster were cleaned on 9/26/11. 16.9 ounce bottle of water was discarded on 9/26/11. The 15 bowls of peaches, 11 bowls of pudding, 2 bowls of deserts, 3 individually wrapped sandwiches and 2 clear plastic bags of sliced ham and one bag of ham chunks were discarded 9/26/11. The Dietary Manager and Assistant audited the entire walk-in cooler for any food items that were not properly stored correctly and discarded as needed on 9/26/11. In the freezer, the bag of frozen tortillas, 2 boxes of frozen peas, 1-15 pound box of bologna were discarded on 9/26/11.	

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F 371	Continued From page 11 Interview at the time of the observation confirmed the debris could fall into the bins when opened. Further observation revealed the standing mixer had brown crust on the inside of the top of the mixer, and the toaster oven had light brown debris on the inside of the toaster oven; interview at this time confirmed the items were covered and available for facilty use. Observation with the head cook on September 26, 2011, at 7:20 a.m., in the walk in cooler, revealed a 16.9 ounce plastic bottle of water one-fourth full, with no label or date, and the following items unlabeled or dated: fifteen bowls of peaches, eleven bowls of pudding, two bowls of deserts, three individually wrapped sandwiches, two clear plastic bags of sliced ham. Further observation revealed one bag of ham chunks, partially wrapped, and the date on the label was illegable. Interview at this time confirmed the itemswere not properly stored and were available for food preparation use by the dietary staff. Observation with the head cook on September 26, 2011, at 7:30 p.m., in the walk in freezer, revealed one bag of frozen tortillas, partially covered with plastic wrap; two boxes of frozen peas stored in a plastic bag not sealed, and one fifteen pound box of bologna stored in plastic wrap and not sealed. Interview confirmed the items were not properly stored and were available for food preparation use by the dietary staff. Observation with the head cook on September 26, 2011, at 7:45 p.m., in the pantry, revealed nine sixteen ounce plastic bottles of soy milk with a sell by date of April 26,	F 371	9 bottles of soy milk was discarded on 9/26/11. 4 opened bags of cake mixes, 5 opened bags of seasoning were discarded on 9/26/11. Sanitizing water was changed immediately on 9/26/11. Dishes that were drying were re-washed and sanitized with sanitizer within proper range. Dishware was pulled immediately and rewashed on 9/27/11. Dishware was pulled and rewashed on 9/27/11. Food was pulled immediately on and re-heated to 140 degrees prior to serving on 9/27/11. The floors and baseboards were cleaned at end of shift on 9/28/11. Vents in front of the steam table, three compartment sink were cleaned by Maintenance on 9/27/11. 3. A daily cleaning schedule was developed to assist with the monitoring of cleaning of all equipment in the kitchen on 10/10/11. Dietary staff will be responsible to monitor and maintain compliance with sanitation standards. The Dietary Manager will audit the cleaning logs on a weekly	

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F 371	Continued From page 12 2011, a blue plastic bin labeled cake mixes with four opened bags of cake mix, and five opened bags of thirteen ounce seasoning not sealed or dated properly. Interview confirmed the items not properly stored and available for food preparation use by the dietary staff. Observation on September 27, 2011, at 10:05 a.m., with the Assistant Dietary Manager, in the dietary department, revealed a three compartment sink in use to manually wash, rinse, and sanitize dishware. Further observation revealed the following manufactures recommendation posted on the wall over the sink, " ...150-200ppm(parts per million)..." Further observation with the Assistant Dietary Manager revealed the sanitizer tested, "...100ppm..." Interview at the time of the observation confirmed the sanitizer was below the manufactuer's recommendation for 150-200ppm. Observation on September 27, 2011, at 11:05 a.m., with the Dietary Manager, in the dietary department, confirmed a blue rack with four shelves of dishware items beside the steam table with dust, and a black debris covering the items. Interview at this time confirmed the items were not clean and were available for use by the dietary staff. Observation of food temperatures on September 27, 2011, at 11:30 a.m., with the Dietary Manager, in the dietary department, revealed the temperature of ground hot dog and mashed potatoes was 120 degrees. Interview confirmed the safe temperature required is 140 degrees, and stated one tray had been served to a resident.	F 371	basis to assure compliance. Administrator will make walking rounds in dietary 3 times per week for the first 60 days, weekly thereafter for 90 days, reassess for further audit and continue as needed, on-going. All dietary staff will be in-serviced on proper cleaning of dietary equipment and the expectations of the facility on 10/12/11. The Dietary Manager will be responsible for conducting the inservice training. The cooks will be responsible to check food temperatures prior to and during service to ensure safe serving temperature. A daily temperature log will be maintained by the cook for each meal 9/26/11 and on-going. A nightly cleaning schedule and checklist will be kept by dietary staff and the dietary manager will audit for the compliance on a weekly basis starting on 10/17/11. After initial opening of an item, all foods will be dated individually with name and date.	

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	F 371 Continued		All foods stored in walk-in cooler and freezer will be covered, labeled and dated. properly. Leftovers will be discarded within 72 hours. A daily shift audit will be completed by the cook at the beginning of the shift and end of shift to ensure all foods properly covered., labeled and dated,. to begin 10/10/11. Sanitizer water will be changed and tested every shift to ensure proper ppm levels. A daily shift log will be completed daily by dietary staff beginning on 10/10/11. The logs will be monitored weekly by the Dietary Manager beginning 10/17/11. The Dietary Manager will be fully responsible for mintaining the sanitation levels within the dietary department. Inservice training will be provided to all dietary staff by the Dietary Manager by 10/12/11. The topics for discussion will be the following: Importance of keeping all equipment in a clean/sanitation condition at all times and the accountability of all staff to keep equipment clean and safe to	

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	F 371 Continued		use, labeling/dating/storing of all food and the discarding of foods within 72 hours of opening, proper 3 compartment sink sanitation usage and the testing for proper ppm's., the maintenance of the floors and baseboards to provide a clean environment for food pre-parathion, correct cooking and serving temperatures for all foods, importance of cleaning and monitoring logs to ensure the dietary department is maintained in a sanitary and clean manner. Discarding of expired food/beverage items and keeping vents in clean manner. This information will be covered in the inservice training by 10/12/11 to al dietary staff. The Dietary Manager will be responsible for providing this training to the dietary staff. by 10/12/11. The vents will be maintained by the Maintenance department through the monthly preventive maintenance logs. The Dietary Manager will also check weekly all vents within the department for cleanliness and operation. This will start 10/10/11.	

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	F 371 Continued		4. The Dietary Manager will present his findings of the individual audits that will be completed each month to the facility monthly Quality Assurance Committee. Any trends will require an action plan developed and implemented by the Dietary Manager. This action plan will become a part of the monthly Quality Assurance reporting mechanism and will remain on the agenda until it has been resolved.	11/7/11

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F 371	Continued From page 13 Observation and interview with the Dietary Manager on September 28, 2011, at 2:50 p.m., in the dietary department, revealed the brown tiled floor was soiled with black substance on the grout, tile, and base boards. Interview confirmed the the tile, grout, and base boards had not be maintained in a clean/sanitary manner. Observation on September 27, 2011, at 2:52 p.m., in the dietary department, with the Maintenance Director, revealed two air conditioner vents; one vent in front of the steam table and one vent in front of the three compartment sink had dust particles and condensation build up. Interview confirmed the vents had not been cleaned.	F 371		
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the area around the dumpsters in a clean and sanitary manner and one of two dumpsters was not covered. The findings included: Observation and interview of the dumpster area on September 27, 2011, at 9:25 a.m., with the Maintenance Director, revealed 20 used disposable gloves, one thirty ounce plastic medicine cup, and other debris on the ground	F 372	1. Housekeeping Supervisor made walking rounds of area adjacent to dumpster and removed the disposable gloves, plastic medicine cup and remaining debris. Completed 9-27-11 Lid on dumpster was replaced by garbage Disposal Company. Completed on 10/4/11. 2. Housekeeping and Maintenance Supervisor conducted walking rounds of facility grounds and removed any additional debris found Completed 9-27-11 3. Housekeeping and Maintenance Supervisor and Maintenance Assistant are making walking rounds daily (Monday-Friday) of the	

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	F 372 Continued		dumpster area and grounds. Begin process on 10-12-11. Housekeeping staff are monitoring dumpster area after trash pick up on Monday-Wednesday-Friday for flying debris. Housekeepers are checking dumpster area at least twice daily as they empty trash. They are responsible to pick up any loose trash found. Started 10-12-11, on-going. 4. Housekeeping Supervisor will make daily (Monday-Friday) walking rounds of the grounds and the housekeeper assigned the afternoon shift will be responsible to make walking rounds of grounds. (Saturday and Sunday). Begin process 10-12-11 Documented results of waking round swill be presented during the monthly Quality Assurance committee. The Housekeeping Supervisor will be responsible for monitoring compliance through he walking round report and if trends occur, developing and action plan. The Housekeeping Supervisor will present the outcomes to the Quality Assurance Committee consists of	

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	F 372 Continued		Administrator, Director of Nurses Bookkeeper, Social Services, Risk Manager, Human Resources, Housekeeping Supervisor, Dietary Manger Medical Director, Maintenance Supervisor, Activity Director. Completed 11-4-11	11-7-11

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F 372	Continued From page 14 around the dumpsters. Further observation revealed one of two dumpsters was missing half of the black lid on top of the dumpster. Further interview with the Maintenance Director confirmed the above items and debris around the dumpsters, and one of two dumpsters was only half covered.	F 372	dumpster area and grounds. Begin process on 10-12-11. Housekeeping staff are monitoring dumpster area after trash pick up on Monday-Wednesday-Friday for flying debris.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	1. Certified Nurse Technician 1 and 2 received counseling reports regarding improper hand washing, and incontinent care on 9-28-11. Certified Nurse Technician # 4 received counseling on hand hygiene and isolation precautions on 9-28-11. Housekeeper #1 received in service education regarding hand washing and isolation procedures on 9-28-11. Certified Nurse Technician # 6 received a counseling regarding hand washing and hand hygiene. LPN # 1 received counseling on infection control related to appropriate wound treatment care, this was completed by Director of Nursing 9-28-11.	

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F 441	Continued From page 15 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview and review of facility policy/procedure, the facility failed to perform proper hand hygiene during care for four residents (#3, #5, #15, #17) and failed to follow infection control procedures during a wound dressing change for one resident (#3) of twenty-four residents reviewed. The findings included: Resident #3 was admitted to the facility on March 9, 2005, with diagnoses including Parkinson's Disease, Cerebrovascular Accident (stroke), Alzheimer's Disease, Dysphasia, Aphasia, Anemia, Generalized Weakness, Decubitus Ulcer, and Adult Failure to Thrive. Observation of incontinence care for resident #3 on September 26, 2011, at 10:10 p.m., in the resident's room revealed Certified Nurse Technician (CNT) #1 and CNT #2 entered the resident's room and donned gloves. CNT #1 assisted CNT #2 with cleansing the resident of stool/urine. CNT #2 cleansed stool from the resident's rectal area in the direction of a wound dressing covering the resident's coccyx, touching the edge of the dressing with the same folded	F 441	2. and 3. Nursing staff was in services on infection control and hand washing protocol by Staff Development Nurse and Director Nursing on 10-6-11. Upon hire and annual review employees will demonstrate proper hand washing techniques. This will be the responsibility of the Staff Development Coordinator and individual department managers. Managers include Administrator, Director of Nurses, Social Services Director, Activity Director, Housekeeping/Laundry Supervisor, Dietary Manager, Restorative Nurse Manager, Maintenance Supervisor and Rehabilitation Director. 25% of facility staff will be required to demonstrate proper hand washing techniques to a number of Nurse Administration team on a monthly basis. Selection of staff will be on a rotating basis. Team consists of the Director of Nurses, Risk Manager, Treatment Nurse (2), Nurse Managers (2), Restorative Nurse, Staff Development Coordinator, and Medical Records Clerk. Failure to achieve compliance will result in mandatory in service training by Staff Development Coordinator.	

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F 441	Continued From page 16 washcloth used to cleanse stool/urine. CNT #1 exited the room twice wearing the soiled gloves to retrieve clean linen from a clean linen cart in the hallway and re-entered the room both times without removing the soiled gloves or washing the hands. Continued observation revealed CNT #2 silenced the alarm on a tube feeding pump (in use for resident #3) with the soiled gloved hand used to cleanse the stool from the resident, then touched the resident's gastrostomy (feeding tube) tube at the connection site to the feeding pump. Interview with CNT #1 and CNT #2, on September 26, 2011, at 10:25 p.m., outside the resident's room confirmed CNT #1 failed to the wash hands when entering and exiting the room twice during care and CNT #2 touched the feeding pump and the gastrostomy tube with soiled gloves. Review of the facility policy, Handwashing/Hand Hygiene revealed, "...Employees must wash their hands for at least fifteen (15) seconds using antimicrobial soap and water under the following conditions ... Before and after direct resident contact, (for which hand hygiene is indicated by acceptable professional practice) ... before and after entering isolation precaution settings... before and after assisting resident with personal care ... upon coming in contact with a residents intact skin ...". Observation of the wound dressing change for resident #3 on September 28, 2011, at 9:15 a.m., in the resident's room with LPN #1 revealed the following: LPN #1 cleansed the wound with a bottle of spray wound cleanser and after completion of the dressing change returned to the	F 441	Begin process on 10-19-11 and on going monthly. 4. Include outcomes of monthly compliance to the monthly Quality Assurances Committee. Committee members include Administrator, Director of Nurses, Bookkeeper, Social Services, Risk Manager, Human Resources, Housekeeping Supervisor, Dietary Manager, Medical Director, Maintenance Supervisor, and Activity. The Director of Nurses will be responsible for monitoring compliance through the generated of compliance maintained monthly by Nurse Administration team. Report to the Quality Assurance committee will include Staff identification, department compliance status and identification of these staff who did not comply and required in service training Staff who were non-compliant will automatically be required to be tested the next month for compliance. Process will begin on 10-19-11	10/21/11

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F 441	Continued From page 17 wound cart and placed the uncleaned bottle of wound cleanser back into the cart for use on other residents. Interview with LPN #1 on September 28, 2011 at 9:36 a.m., outside the resident's room, confirmed the bottle of wound spray was to be used for multiple residents, and the bottle was not cleaned prior to being placed back into the wound treatment cart. Resident #5 was admitted to the facility on July 13, 2011, with diagnoses including Weakness, Confusion, Dementia, Hypertension, Joint Stiffness, and Urinary Tract Infection. Observation on September 27, 2011, at 8:45 a.m., in the resident 's room, revealed Certified Nurse Technician (CNT) #4 set up resident #5's roommate's breakfast tray; pickup up items off the floor then proceeded to adjust resident #5's position and the covers. Further observation revealed CNA #4 then exited the room, retrieved a breakfast tray from the food cart in the hallway, reentered the resident's room and placed the tray on the bedside table, without washing the hands. Interview with CNT #4 on September 27, 2011, at 8:45 a.m., in the resident's room, confirmed the CNT did not follow proper handwashing procedures. Review of the facility policy, Handwashing/Hand Hygiene revealed, "...Employees must wash their hands for at least fifteen (15) seconds using antimicrobial soap and water under the following conditions...Before and after direct resident contact, (for which hand hygiene is indicated by	F 441		

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F 441	Continued From page 18 acceptable professional practice)...before and after assisting resident with personal care...upon coming in contact with a residents intact skin...". Resident # 15 was admitted to the facility on August 8, 2011, with diagnoses of Chronic Kidney Disease, Dementia and Hypertension. Medical record review revealed the resident was placed in contact isolation due to a diagnosis of Clostridium Difficile and was receiving treatment. Observation on September 27, 2011, at 3:00 p.m., outside the residents room, revealed a sign stating "Stop, see nurse prior to entering room". Observation on September 27, 2011, at 3:15 p.m., outside the resident's room, revealed housekeeper #1 entered the resident's room wearing gloves. After cleaning the room and mopping the floors, the housekeeper removed the gloves and exited the room without washing the hands and stated "...resident is in isolation due a bacterial infection...". Interview with housekeeper #1, on September 27, 2011, at 3:17 p.m., in the hallway outside the resident's room, confirmed the hands were not washed prior to leaving the resident's room. Review of facility policy, dated August 1, 2003, titled Isolation Precautions- All Departments, states "...all care givers, as well as ancillary personnel, shall follow the established isolation precautions...". Further review of facility policy titled, Personal Protective Equipment-Using Gloves, states,"...Wash hands after removing	F 441		

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F 441	Continued From page 19 gloves (note: gloves do not replace handwashing.)...". Facility policy, titled, Isolation-Categories of Transmisson-Based Precautions, dated June, 2010, revealed,..."Transmission Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted...with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the residents environment...Examples...ClostridiumDifficile...we ar gloves when entering room...change gloves after contact with infective material...remove gloves before leaving room and wash hands immediately with antimicrobial agent or a waterless antiseptic agent,...after removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room..." Interview with the Director of Nursing (DON), on September 27, 2011, in the DON office at 4:00 p.m., confirmed the hands are to be washed prior to leaving the resident's room. Observation on September 28, 2011, at 7:57 a.m., outside the resident #15's room, revealed CNT #4 entered the resident's room with a food tray. Further observation revealed the CNT did not place gloves on the hands prior to entering the room and assisted resident # 15 in set-up of the food tray. Continued observation revealed CNT #4 exited the resident's room without washing the hands, went to the food cart, got another tray out of the cart and turned to take the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445160	A. BUILDING _____ B. WING _____	09/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 20 tray to another resident. Interview on September 28, 2011, at 8:00 a.m., in the hallway, with the CNT #4 and the Director of Nursing (DON) confirmed the CNT failed to follow the facilities policy for hand hygiene. Resident # 17 was readmitted to the facility on September 23, 2011, with diagnoses including Urinary Tract Infection, Failure to Thrive, Dysphagia, and Pressure Ulcers Right Heel and Coccyx. Observation in resident #17's room on September 27, 2011, at 7:38 a.m revealed CNT #6 set up resident #17's roommate's food tray and then assisted resident #17 with repositioning the resident's covers, rearranging pillows, and elevating the head of the bed. Further observation revealed the CNT then exited the resident's room, poured coffee from the top of the food cart, retrieved a food tray, and returned to the resident's room without washing the hands. Interview with CNT #6 on September 28, 2011, at 7:40 a.m., in the resident's room, confirmed the CNT failed to wash the hands between residents, before retrieving the food tray and pouring the coffee. Review of the facility policy, Handwashing/Hand Hygiene revealed, "...Employees must wash their hands for at least fifteen (15) seconds using antimicrobial soap and water under the following conditions...Before and after direct resident contact, (for which hand hygiene is indicated by acceptable professional practice)...before and	F 441		

OCT 14 2011

STEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445160	A. BUILDING _____ B. WING _____	09/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21 after assisting resident with personal care...upon coming in contact with a residents intact skin...".	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to clean return air vents in the ceiling on the South Wing and the Dining Hallway for four of six vents observed. The findings included: Observation on September 26, 2011, at 8:30 p.m., on the South Wing and dining hallway, revealed dust particles hanging from the vents and the filters were covered with dust on four of six vents observed. Interview on September 26, 2011, at 8:55 p.m., with the maintenance director, in the South Wing hallway, confirmed the vent grills had dust particles hanging from the ceiling and the filters were covered with dust on four of six of the vents observed and confirmed the filters had not been changed and the ceiling grills had not been cleaned. Further interview confirmed the facility did not have a scheduled maintenance for changing the vent the filters and the filters needed to be changed and cleaned.	F 465	1. The vent grills were cleaned on 9/27/11 by Maintenance.. The filters were replaced on 9/27/11 by Maintenance. 2. Maintenance Supervisor and Assistant audited the building for dirty vents on 9/28/11. Replaced dirty filters as needed on 10/18/11 3. The Maintenance developed a Preventive Maintenance log to track checking vents and for the routine changing and/or cleaning of vent filters. Completed by: 10/18/11 The Maintenance will monitored the facility through the log to determine that vents and filters are addressed on a timely basis. Daily (Monday-Friday) departmental compliance rounds will include monitoring of vents and dirty vents will be reported to the Maintenance Supervisor for follow-up. Completed 11/7/11 The Quality Assurance Committee consist of the Administrator, Director of Nurses, Bookkeeper, Social Services,	

OCT 14 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445160	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	F 465 Continued		Risk Manager, Human Resources, Housekeeping Supervisor, Dietary Manager, Medical Director and Activity Director. 4. Maintennance Supervisor will bring the monthly log to the Quality Assurance Committtee to show compliance. Trends will require an action plan and this will be presented to the Quality Assurance Committee for a monthly follow-up until such time it is resolved.	11/7/11